COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

February 4, 2020
9:30 A.M.
Thompson Conference Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky

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AGENDA

1. Call to Order, Welcome & Introductions

2. Approval of Minutes/Report from the November 5, 2019 PTAC meeting
   (September meeting minutes need to be updated on the website as noted in November meeting minutes)

3. Review of previous Pharmacy TAC Report to the MAC

4. Roundtable Report out on Current State of Affairs
   * Department of Medicaid
     - Welcome Commissioner Lee
     - Update from Commissioner Lee
     - Medicaid member copays
       * Follow-up: Dr. Joseph was to send "cheat sheet" document for pharmacists to Mark Glasper for distribution
     - 340B Policy
   * Humana
   * Aetna
     - CPESN update
   * WellCare
   * Anthem
   * Passport
   * PTAC Committee members

5. Follow-up on previous agenda items
   * Pharmacist reporting immunizations to KYIR update
   * DMS Quality Strategy - how can pharmacists in KY help
     - Review of meeting with Commissioner Steckel/ Jessin Joseph on 11/5/19
       * Payment models to allow pharmacists to focus on quality and patient outcomes
   * Next Steps

6. New Business/Take-aways

7. Reports and recommendations from the PTAC to the MAC

8. Other Business

9. Next Steps
   * Next MAC meeting - March 26, 2020
   * Next PTAC meeting - April 21, 2020

DR. FRANCIS: Good morning, everyone. I think it's straight at 9:30, so, we will get started. I appreciate everyone being here and lots of new faces. So, we definitely want to have welcome and introductions today. So, I will start and then we will introduce the TAC and then go around the room.

(INTRODUCTIONS)

DR. FRANCIS: So, thank you again, everyone, for being here.

Our first order is I wanted to review the minutes from November 5th. I emailed them out to the TAC and they are posted on our Pharmacy TAC website. Sharley, was November's posted? The last I looked was September.

MS. HUGHES: No. I don't post them until they are approved by you all.

DR. FRANCIS: After we approve them. Okay. So, TAC members, did you get a chance to read the minutes?

MR. CARRICO: I make a motion to approve.

MS. MILLER: I just wondered about the correction on this section. It says MAT. It should say MAC.

DR. FRANCIS: I had that, too. Where it says Senate Bill 5 data report release, Dr. Joseph was talking about the MAC prices - M-A-C as in cat, not M-A-T, so, if we can make that correction.

MS. HUGHES: Okay. That was in September or the November?

DR. FRANCIS: November.

MS. HUGHES: Okay. And I can go back and look in the November meetings and see the changes for September that we needed to make and I'll get the court reporter to make those.

DR. FRANCIS: Okay. So, other than that correction, anything else? Just the one, Paula?

MS. MILLER: Yes. That's all I have.

DR. FRANCIS: Okay. So, if we correct that, I think, then, we approve the minutes.

I also have on the agenda that I wanted to review the report I gave to the MAC, at the November meeting to the MAC. Since we have a lot of new faces, I wanted to make sure that everybody was consistent on what the TAC has been working on which we will talk a lot about today, but just to give everyone an overview, I'll go ahead. I don't

believe it's printed, but since this isn't published on our website, I believe the MAC just has it, right?

MS. HUGHES: Right.

DR. FRANCIS: So, the Pharmacy TAC last met on November 5th. There was a quorum with five out of five members present.

The TAC had a productive discussion with the DMS Pharmacy Department and MCOs about various topics relating to DMS and pharmacy-related issues in our Commonwealth.

Notable discussion items included Dr. Jessin Joseph of DMS provided an update on the member copays posted to KyHealth.net portal stating that the actual dollar amounts a member has paid out of pocket will not be shown because they change daily, yet, a threshold is triggered to show yes or no that a copay has been met once the 5% threshold amount is reached for the quarter.

So, we have communicated those types of things out to pharmacists throughout the state and post to help educate pharmacists and educate the members in understanding their copay structure and how it might change quarterly.

Dr. Joseph also provided an update on Senate Bill 5 data reporting. DMS was

monitoring the MAC prices and their algorithm appears to be accurate but it's based on the national market and may not be reflective of Kentucky itself.

DMS is investigating Kentucky-specific actual acquisition costs of drugs and will involve Kentucky pharmacists in the discussions if needed. That sounds accurate.

And, then, Anthem Medicaid is now live with Ingenio Rx as of October 1st and Humana will be moving to the Humana Pharmacy Solution PBM starting January 1st.

And DMS provided an update on the 340B policy and stated that DMS took feedback from all covered entities and the responses and a final notice was sent out. The current effective date is January 1st, '20 with a grace period to April 1st, '20 for pharmacists and covered entities.

And, then, I noted that I'm leading a workgroup to improve pharmacy reporting of immunizations administered to the Kentucky Immunization Registry and this is happening through KHIE.

And, currently, this was back in November, about 13% of pharmacies are putting data into the Registry and about 8% are getting data from

the Registry.

The workgroup continues to investigate barriers for pharmacy immunization reporting while also educating stakeholders to onboard with KHIE or Kentucky Immunization Registry to contribute to this important public health need and we'll have an update on that today. too.

And the Pharmacy TAC reviewed the five goals included in the DMS Quality Strategy which the five goals are behavioral health and substance use disorder, chronic disease management, wellness and prevention, health transformation and value-based care, and special population focus.

The TAC believes that pharmacists are well-positioned to help Medicaid improve the health of members in each of these areas but a payment model for pharmacists' non-dispensing services within their scope of practice will be required.

So, the Pharmacy TAC and others will work on gathering research data and potential cost savings to support this idea.

We did not have any formal recommendations to the MAC, but that kind of gives you a background of hopefully where we will launch

from today, and I'm sure a lot has changed in Medicaid, too. So, we will get going on that.

Commissioner, the way I like to formulate these meetings is give DMS just a chance to give us an update on all things pharmacy, maybe even some things not pharmacy that you're working on and report those out, and, then, I give all the MCOs a chance to give any updates on their end and, then, we will go from there.

So, I know Jessin has been a part of these in the past and probably has some information to share. So, welcome to you and thank you for being here and I'll give you the floor.

COMMISSIONER LEE: Glad to be back. And for those of you who maybe are not familiar with me, I am a previous Medicaid employee. I worked in the Kentucky Department for Medicaid Services for sixteen years before retiring a few years ago.

During my tenure at Medicaid, I served as a Member Services Representative, a Provider Services Representative, a Policy Analyst. I did a lot of things in the sixteen years when I worked in Medicaid.

So, I'm very familiar with the

issues facing the population we serve, also familiar with some of the issues that providers face on a routine basis in serving and delivering care to our members, and I just look forward to working with all of you as we drive positive policy change to impact the lives of our members.

We know that pharmacy is one of the top spins in Medicaid. We also know that there's a national spotlight on pharmacy, particularly around high-cost drugs, those sorts of things. So, again, we just look forward to working with you to find out what we can do to improve the lives of our members.

And I can just go on into updates, if you want me to.

DR. FRANCIS: Sure. Yes, please.

COMMISSIONER LEE: As many of you know, Governor Beshear has rescinded the Kentucky HEALTH Waiver. Certain portions of that waiver, though, will remain such as the substance use disorder treatment portion and the KI-HIPP. That's the health insurance premium payment assistance program for individuals who may have access to employer-sponsored insurance. Medicaid essentially pays their premium and they receive their benefits

through their employer insurance and, then, Medicaid will pay wraparound services for those things that are not covered in their employer-sponsored insurance.

We are keeping an eye on everything pharmacy-related in the Legislative Session. We are currently right now kind of analyzing and looking at Senate Bill 50.

We have a little bit of a concern about the carve-out of 340B from the - or leaving the 340B in the Managed Care Organization and carving out the rest of the pharmacy.

We're not really sure how that would work, not sure if CMS would even approve such a thing. So, we're still kind of analyzing that and looking to see what impact that would have if that legislation passed.

Dr. Joseph, would you like to provide additional updates?

DR. JOSEPH: Sure. So, Medicaid member copay, I do have a cheat sheet ready. I have been waiting to send it out just to make sure everything is good on our end.

We are discussing where we're going to go with the copays. So, I will make sure we

get that out to you, but, again, it will just be the indicators that's going to be out there but it should be pretty straightforward about where to look.

DR. FRANCIS: At this time, has anything changed, I guess?

DR. JOSEPH: Nothing officially, nothing officially yet. So, it would make sense for me to share it with you all as soon as possible, but if a change does occur, then, I will notify you about that as soon as possible.

MS. MILLER: This is on the Health.net?

DR. JOSEPH: Yes, the Kyhealth.net, yes.

The 340B policy, there's nothing really new to it. It's been out. The effective date is 1/1, meaning that the State can now collect that information at the claim level. However, we won't be enforcing it until 4/1. The reasoning behind that was hopefully pharmacy practice can get adjusted to the change and, then, making sure that our systems were capable of handling all that.

DR. FRANCIS: Does all the data seem to be flowing well?

DR. JOSEPH: Yes. It seems to

be running fine through the point-of-sale system, more particularly with our fee-for-service system. With the MCOs, it's going to be dependent on when they submit the data to us. So, nothing is truly point-of-sale for us at our end because obviously it will run through the MCO's PBM first and, then, it will get sent to us.

So, by then, we'll know what the indicators are on which claims. So, it will still be there. It's not going to necessarily be an issue. It's just we'll know it for the end of the quarter when we actually do our federal rebates as required by CMS.

But other than that, we really don't have anything else. All of the documents for 340B is already on our website. So, if HRSA does choose to audit any 340B-covered entities, covered entities do have a document from DMS that indicates our policy.

And, so, if a person does have questions, you can direct them to us, but, really, all the questions should be answered via that document. As long as the identifier is on there for all point-of-sale claims and for physician-administered drugs, the UD modifier is on there,

there shouldn't be any other issues beyond that.

MR. CARRICO: We've talked about this on the phone before. I just need clarification. For Part D patients that are dual eligible, the 20 modifier still will go on the Part D claim?

DR. JOSEPH: Yes.

MR. CARRICO: Now, I thought I had this all down and someone threw a monkeywrench in it. Is all LIS dual eligible or all dual eligible or just LIS?

DR. JOSEPH: I'd have to look into that, but when you say the 20 modifier, are you talking about the UD modifier?

MR. CARRICO: No, the submission clarification code.

DR. JOSEPH: We're not going to mandate - yes. If we're covering any of the payment on that drug, then, we'll require the 20 but I don't know about the LIS. I'll have to look into that. LIS versus the duals?

MR. CARRICO: Right, because I thought it was Level 0 through 2. We're dual eligible on the LIS. Our system just now told us which level people were in LIS when you start looking this up, and January 1st, that was new to us.

DR. JOSEPH: Okay.

MR. CARRICO: So, I was just kind of making sure which ones are considered dual eligible on the LIS scale.

DR. JOSEPH: I will check for you, but to play it safe, I would say if they are dual for now, just ensure that the 20 modifier is on there for those patients.

MR. CARRICO: I'm slapping it on all LIS for the moment just to be safe until I get more clarification.

DR. JOSEPH: Sure thing. The way that we will look at it is the same way that CMS will look at it. So, even if Medicare covers a majority of the cost of the drug and Medicaid is left with paying a penny, we are responsible for identifying that claim, so, we're going to require the modifier. A rebate on a penny is nonexistent but it still has to go through the process.

One thing I do want to note was Humana, I believe, went live 1/1 and I think it was fine. Anthem was fine.

Some pharmacists did reach out to me regarding an Express Scripts' contract and it was worded funny because, of course, Express Scripts

is no longer a PBM within our state but they did reference Medicaid. We believe they are referencing other Medicaid Programs.

So, in regards to 340B and identifying 340B claims or putting an indicator on for their claims, we're not mandating that through Express Scripts. There were a handful of emails on my end that came through, but, again, we don't work with Express Scripts in any way. We don't have subcontracts with them anyways, so, just to clarify.

If other PBMs are reaching out about Medicaid contracts and it's not either Humana Pharmacy Solutions, Ingenio or CVS, it is a different Medicaid Program, a different state's Medicaid Program.

DR. FRANCIS: Anything else from DMS at this point? No.

So, we will go with Joe and Humana.

DR. VENNARI: Good morning. Just a couple of things. We went live with Humana PS on 1/1. There were a couple of glitches. One, we had some fosters were paying copays. So, we made a call to stop all copays until it was fixed. It has been fixed for about ten days. So, that's good now

and the plans will process 100% correct.

And, also, when we first started, we noticed a relatively high denial rate and this was primarily because of BIN/PCN change and we subsequently communicated and faxed out and that has dropped dramatically.

One CVS chain does a lot of auto fills. So, that tended to raise the denials a little bit higher than normal; but once they come in and we see it, they do start processing fine. So, everything is back in order.

DR. JOSEPH: And everything for the BIN/PCN's is updated on our site as well.

DR. FRANCIS: For all?

DR. JOSEPH: For all.

DR. VENNARI: And you don't need a group for Humana. You don't need a group, just BIN/PCN.

DR. FRANCIS: And one thing I wanted to make sure, I apologize, April Cox with Aetna came in the room, and typically what happens is I email out the agenda and the previous minutes to the Pharmacy TAC and to Sharley and she is supposed to upload the agenda to the website.

We're supposed to check the

website for the agenda, but if the MCOs would all like me to do that, I will do that as a courtesy to email that out. I know that that's probably more convenient for you.

So, please see me after to make sure I have your correct email addresses. Anything else?

DR. VENNARI: That's it.

DR. FRANCIS: Okay. Aetna. April.

DR. COX: Good morning. We have a CPESN update. So, we are still working on expanding our program. We did add one additional pharmacy before the end of 2019 - Beringer. So, they are fully on board now. We still have the other six existing pharmacies, so, we're up to seven.

We now are working through what we call a pipeline report. So, we're looking at additional pharmacies across the state to join the program.

So, we're looking to see if there already is a CPESN program, if they have vendor capability because that's like a big part of the program to be able to submit your care plans and making sure that the vendors are compatible and can

send over the components that are necessary.

So, we have several pharmacies in the works right now that we're trying to get onboard. They're sending in sample care plans so that we can test them out to make sure they meet our case management needs.

And, then, we have a new partnership with Paula. So, I don't know if you want to add any information there.

MS. MILLER: Well, I'm just working as a network facilitator for the Kentucky CPESN network. So, I'm going to help try to expand opportunities for pharmacists to become involved and different pharmacies. So, I look forward to working with you, April.

DR. FRANCIS: I'd like to just give for everyone new in the room what we're even talking about with CPESN and what that means because I think it's important as we try to coordinate care between pharmacists and their providers.

CPESN is really a program, especially for independent pharmacies but it can be for anyone, if you've heard of eCare Plans, to kind of integrate information across systems. And I can probably let Paula explain that as she is a luminary

for the program nationally and, then, we can maybe just explain a little bit what Aetna's pilot program has done just to make sure that everybody is up to speed.

MS. MILLER: So, the background of the program, CPESN stands for Community Pharmacy Enhanced Services Network. So, it's a clinically-integrated network relatively new in the pharmacy side with the idea that pharmacists can be a type of medical home and coordinate care with providers, physicians, nurse practitioners, also patients, family members and health plans.

So, we use a platform that produces an eCare Plan which is a similar type of documentation system that you will see in hospitals and doctors' offices where everything is reduced to SNOMED codes which, of course, is a universally-accepted code that everyone understands.

So, it is a big change for pharmacies to reduce our work as clinicians to a digital format. So, there is a lot of work on the pharmacy side to be able to produce the eCare Plan.

We rely on outside vendors to help us do that and that's what April is referring to. We have to contract with an eCare Plan vendor in

order to communicate with the health plans and eventually with hospitals and physicians.

So, Kentucky's network is growing and we look forward to having more pharmacies on board.

DR. COX: And, so, what we have done specifically with Aetna with the care plan model, we have a dedicated case manager and one of our case managers that work directly with the program.

So, our case manager, she has monthly calls with all of the pharmacies to address any issues that they may be experiencing, to go over the care plans that they have submitted. By all means, they can reach out to her more often if necessary but she tries to at least meet with them monthly to go over any of the care plans that have been submitted.

And, so, a lot of the initial care plans that we've seen have been more polypharmacy. So, the pharmacist is identifying any issues that may exist with the member's medication, where there's a gap in care or duplication of therapy or anything like that.

So, they are identifying those

issues, sending those over to us. They're doing provider outreach to also try to address the concerns that they've seen and see if the provider will take their recommendation.

And, so, if the provider does, then, that could close a gap in care or change a dose in medication, maybe get dose optimization and, then, they can include that on their next care plan as this is the issue we identified, reach out to the provider and do the resolution.

And, so, we track all of that in our case management system and that way we're really using the local pharmacist as that middle person that face with the member because they usually have these established relationships with the members from a health plan perspective.

Even though we enroll a lot of our members in case management, it's not the same as that face-to-face interaction that you get with your pharmacist that you see every day. And, so, it's really helping us to build a better relationship with some of our members as well.

We've been able to identify some issues of social determinants of health through the program. We've also given out backpacks where we

have included nutritional foods, items. Like, for the wintertime, we provided blankets and hats and scarves, that type of thing in the backpacks for the pharmacies to give out to members.

So, so far, I think it has been very successful and I think we just started to tap the surface of where the program can go.

DR. FRANCIS: And the six pharmacies that have been on it are in Western Kentucky and, then, Beringer's is Beringer in Warsaw, Gallatin County, right?

DR. COX: Yes.

DR. FRANCIS: So, I'm looking forward to seeing how it expands. Do you think maybe at our next meeting, you might be able to bring us some data results?

DR. COX: If you can give me a second, I can pull it up. I have a few numbers I can give you statistic-wise. So, let me pull those up and I do have some statistics I can share with you about how many members we've seen, care plans, case closures, that type of stuff. So, I do have that today.

DR. FRANCIS: Okay. We can come back to you.

MR. CARRICO: I have a question on CPESN. Do you know if it's expanding into Eastern Kentucky anytime soon? I know I'm in the unhealthiest county in the state and I have plenty of candidates for this program.

DR. COX: So, we are looking all around. And, as Suzi said, we started in Western Kentucky just in the Region 4 area. So, right now, we're looking throughout.

So, we're not just going to expand by region, kind of like how we started. We may take a couple in Region 2, a couple in 5, whatever. So, right now, we are looking all throughout the state. And, so, if you want, we can touch base after the meeting and discuss it.

MR. CARRICO: Sure. Sounds great.

MS. PARKER: When does this start?

DR. COX: We started January 1st of last year. So, we have been a year in.

DR. FRANCIS: Thanks, April. WellCare.

MS. ROGERS: I don't have a lot to update really. It's pretty much status quo for

WellCare. We did implement some formulary changes. Anoro Ellipta is now non-preferred. Sliolto Respimat is the alternative. Members have sixty days to grandfather and, then, we added Alogliptin as a step for Januvia, but all of that is also posted on our website and it's been shared.

We have expanded some for Part D into some counties in Eastern Kentucky and we continue to work on our quality strategy as well for Medicaid and Medicare. So, that's the highlights that I have.

DR. FRANCIS: Anthem.

MR. RUDD: I don't have a whole lot to report. Ingenio has gone live as you said in October. We've got two months now basically of good data and it seems to be working pretty problem free with the claims processing and everything associated with the new PBM.

We are working internally on an opioid strategy and monitoring that as well as SUD. Since we've increased access, we're continuing to monitor that and watch changes in utilization, and patients are obtaining more treatment than they were previously.

DR. FRANCIS: And Passport.

MS. ARMSTRONG: Not a lot of updates for Passport. We're just preparing for our first P&T meeting that's on February 20th. Other than that, everything is going well.

DR. FRANCIS: Okay. So, maybe like Quarter 2, we might see some changes.

MS. ARMSTRONG: Yes.

DR. FRANCIS: Okay. And, April, you let me know when you're ready.

DR. COX: I need a couple of more minutes.

DR. FRANCIS: Sure. PTAC members, any updates on our end?

MR. CARRICO: I had more of a follow-up. I kind of gave this about six months to see if anything changed before I bring it back up again, but the NIX Permethrin 1%. I'm with ABC, a large wholesaler. They have no generics available. It's only been the brand name. The brand name is not covered on any of the MCOs.

I even ran through the generics they allegedly have, even though they're not in stock, and only could find one that worked on all. WellCare, I couldn't find any generic NDC's.

And I know it's a little more

complicated with over-the-counter products and having to set up for rebates and stuff but help. I'm having a hard time looking parents in the face that are struggling or kids that need this and saying, sorry, you're going to have to pay for the brand name, and sometimes they can't afford it and I'll have to give it to them. Other times, they will pay.

But, please, if you know where I can get some of this generic and when it's covered, tell me, or what do we need to do to get the brand name covered because this has been going on for over twelve months, at least through my wholesaler, and I have a hard time thinking I'm the only one.

And over-the-counter products are not the easiest to buy from side vendors, specifically this one in particular. So, I am asking politely, please, help me.

MS. BATES: What's the drug? What'S it for?

DR. FRANCIS: For lice.

MS. BATES: And the MCO doesn't have something available for that?

MR. CARRICO: The wholesaler doesn't have any of the generic product available. It's been over a year, and I just kind of ran through

the generics that they carry, even though they're not available, to see which ones are covered, and I'm having a hard time finding a generic that's covered. The brand is available but the brand is not covered.

DR. FRANCIS: So, would it help if - first of all, I guess, if a product became available, if the plans would send us the NDC's that they covered and, then, in light of maybe NDC's not being available, could they add Nix?

DR. COX: I'm thinking - and correct me if I'm speaking out of turn - the NDC's that maybe are available, are they not CMS rebate eligible? So, that's part of the problem?

MR. CARRICO: I'm not sure but I don't know where else I can get it.

DR. COX: Because I know I had another pharmacy reach out to me for the same thing and that's what we found. They actually did have a generic - and don't ask me which one it was because I don't remember - but when we ran the NDC, it wasn't on the CMS rebate eligible list.

MR. CARRICO: That happened to us when they did have one generic available for about a week, but, like I said, I can't even find it through side vendors. So, I'm not even sure where I

can buy the product of a generic that is CMS rebate eligible to run through a Medicaid at the moment.

DR. COX: Is the Nix brand, is that available right now?

MR. CARRICO: The Nix brand is available. So, I don't know why the generics aren't but the brand has been available the whole time. And this might not be the case with every wholesaler. I just know it's the case through AmeriSource.

DR. JOSEPH: Matt, have you ever run a fee-for-service child at all for this at all?

MR. CARRICO: I don't think I have any children on fee-for-service.

DR. JOSEPH: All right. Then, we will take a look and see what is going on on our end and see if there are any CMS rebate eligible in the state.

MR. CARRICO: Thank you.

COMMISSIONER LEE: I'm just thinking. The EPSDT benefit, I mean, anything that's medically necessary for a child. I'm not sure how that would work with brand versus pharmacy, I mean, with the pharmaceuticals, brand versus generic, but that's something else that we might need to look into with the EPSDT benefit.

MS. BATES: And the bottom line is that the MCO needs to do the work to try to make this available. That's the bottom line because you don't want parents out there having to pay for something. If there's a barrier there, they need to look into that.

COMMISSIONER LEE: Is everyone familiar with the EPSDT benefit?

MS. MILLER: Is that only for people on waiver?

COMMISSIONER LEE: No. It's called the Early Periodic Screening, Diagnostic and Treatment benefit and it's for children under the age of twenty-one and it basically states that any child should receive any service that's medically necessary, and this definitely, I would think, is medically necessary. There are a few limitations but I wouldn't see why we couldn't cover something under the EPSDT benefit.

DR. FRANCIS: So, you're saying that under that, it should be able to be added to any formulary, the brand name?

COMMISSIONER LEE: Yes. We should be able to override or do something in order to get that or the MCOs should be able to do

something in order to get that child that benefit.

MS. BATES: And maybe not added to the formulary formally, but if what is on the formulary isn't available, they need to make something else available so that way the child can get the treatment.

MR. CARRICO: And I know we're trying to save money and avoid brand name products, but the brand name product is only a couple of dollars more in this case.

MR. KAYE: Can you not use a DAW code?

MR. CARRICO: I've not been able to get one to go through on any MCOs for DAW.

MS. ROGERS: We'll take it back, Matt. I'll definitely take it back to our team.

DR. FRANCIS: And the MCOs did take it back the first time and we thought----

MS. ROGERS: I thought we had some added that were covered. I know that different NDC's at different times, wholesalers have shortages and we definitely want to stay abreast of that. So, thank you for that feedback.

MR. CARRICO: I don't think anyone thought this, at least with my wholesaler,

this shortage was going to go on for twelve months. It's kind of impressive that the brand has been available the whole time and generics are not. Do you use AmeriSource?

MS. MILLER: I don't and I don't have a lot of children at my stores. So, I've not seen a lot of requests.

DR. FRANCIS: Anything else from the Pharmacy TAC? If not, I have one item.

I just wanted to mention, we do have a quorum today. We have three out of five members, but, unfortunately, Chris Betz couldn't be here last minute.

Cindy Gray, her term was up, and, so, she has elected to step down off the TAC. And, so, KPhA is currently going through the process of accepting nominations for the Pharmacy TAC and the KphA Board will select a new Pharmacy TAC member and we should have that by the next meeting.

Let's go to follow-up on previous agenda items. I told you that we would have an update on - one thing back when Dr. Liu was the Medical Director for Medicaid is he graciously allowed all immunizations within a pharmacist's scope of practice, so, age nine and up, to be covered by

MCOs at the pharmacy, as a pharmacy benefit.

Through that, he also asked that pharmacists please try to support and encourage reporting to the Registry through KHIE.

So, I have been working on that. We have been working on that, not just through pharmacists but I've been working with Dr. Connie White and helping other providers or schools or whatever, anyone that provides immunizations to try to report to the Registry through KHIE.

So, just to catch you up to speed as to where we are, actually, the same day we met with the Pharmacy TAC in November, we then went and met with KHIE afterwards. Paula was there and Matt was there and myself and some others.

And we are looking at all of the different pharmacy operating systems and how they are able to integrate with KHIE. And, so, we're investigating that some more.

KHIE does not charge for pharmacists to integrate and report but some of the vendors do charge, and that puts some burden on pharmacies.

So, we have been working through that and also just education is a big thing

as to how to educate all the different pharmacists out there, if the immunizations they're giving are being reported by their corporation or if they need to sign up. So, we're working on that.

Paula, you have a meeting actually today, I think, for your own pharmacy but was going to follow up again for us.

And, then, also, one thing that you will see we mentioned or at least I mentioned, KHIE will have some grants available for pharmacists or pharmacies to be able to supplement some of these costs and they will be up to $8,000 to help them onboard.

So, KphA is helping spread that word and Paula could probably tell you a little bit more of the specifics about the grant.

MS. MILLER: That's pretty much all they're saying right now. It's up to $8,000 to apply to offset the cost of integrating with the system. So, that's where our cost lies right now.

MS. HUGHES: According to an email I got this morning, the application to apply for the grant is now on the Kentucky Health Information Exchange website.

MS. MILLER: It's on the website

now?

MS. HUGHES: Yes.

DR. FRANCIS: So, we will work to communicate that out to pharmacies throughout the state. Then, I'm also working with the larger chains to see if we can work through the necessary means to get everybody reporting.

We'll give status updates as to how many pharmacies are reporting. I think every time I investigate, I learn more and more. Even within my own system - I'm on Epic - and we didn't realize that only children query automatically. If they're adults, we have to manually go in and query to get their updated immunization records from KHIE.

So, we're working through all the electronic things but we are working on it. So, I think that will be helpful in the public health realm.

Any other questions on the immunization?

MR. CARRICO: I know at the last meeting, we discussed the possibility of DMS being able to report immunizations they receive through the MCOs to KHIE. Is that still a possibility?

DR. JOSEPH: Yes. Actually, I

talked to Andrew with KHIE and it sounds like he actually takes that information and already inputs it into the Immunization Registry.

DR. FRANCIS: Your claims?

DR. JOSEPH: Yes, using the claims data since that will be the source of truth at some point or for now. We'd like to shift over to the Immunization Registry, but, yeah, we're going to confirm that. I think I may be at the same meeting.

MS. MILLER: Are you coming, too?

DR. JOSEPH: Yes, this afternoon at some point. We'll touch base with Andrew but it sounded like that already happens and we just need to confirm that it does, and he let me know about the grants, but it sounds like you guys are already up to date on all of that.

DR. FRANCIS: Yes, and we're trying to work towards that. I think the grant will be really helpful, especially for the independent pharmacies.

DR. JOSEPH: Yes. And I think there are restrictions about who can use the grant. So, I think it's tailored towards independents. National stores can pay their own costs.

MS. HUGHES: And the email did say it was on a first-come/first-serve basis. So, you may want to get your applications in fast.

DR. FRANCIS: Right. So, we are working on that. I will say just for your knowledge, the increase in access through pharmacists has really been helpful.

I know I personally have immunized hundreds of kids to get them back into school for the Kenton County school system because their superintendent is sticking to the immunization regulations. So, we offer a place where parents can bring their kids and be able to get that into the Registry and get their certificate printed.

The next was DMS Quality Strategy, and I might need a little help from DMS on this, first of all, the status of the Quality Strategy with the structure of DMS changing. Is that still active?

MS. PARKER: I can address that. As you know, the Quality Strategy for 2019 was submitted to CMS August 5th and we have not heard back from them on it.

However, if you've read the Quality Strategy, in the very first paragraph, it

says it's a dynamic document. So, we already know it needs to be changed and it's starting to be worked on for that.

So, when we are updating it and resubmitting it to CMS, when I checked with them in December, they had some turnover of people who were reviewing that and they said it was in the pipeline, but I already know that there are changes to be made in that, and how we redevelop it, obviously it is a collaboration with all medical entities and our MCOs and the programs that they are offering.

So, I guess my question to you is how would you foresee your contributions to it?

DR. FRANCIS: So, I think that, first of all, we as a Pharmacy TAC have been very much - I mean, we talk about things obviously that are hands-on and very real, like getting Nix covered to treat a condition, but we also want to see how pharmacists can be available to improve the quality of members all throughout the state.

So, I feel like if we align ourselves with DMS' Quality Strategy, that's going to help both of our efforts so we won't be going in two different ways.

MS. PARKER: The alignment of

the Quality Strategy is with the MCOs. So, whatever programs, like the one that you just talked about, they will be helpful in that because it is basically a Managed Care Quality Strategy. It's a recommendation or something that we have to follow based on CMS rules.

DR. FRANCIS: Sure, and you're going to carry that out through the MCOs.

MS. PARKER: Yes, and there are a lot of things that we have to make sure that are in that Quality Strategy that is dictated by CMS as well.

DR. FRANCIS: Okay. So, in the past, I have reached out to MCOs and we've talked about how we can work together as pharmacists to pilot something, work on something to where we have, like April said, all of these accessible face-to-face touch points with patients throughout the state, how can we as pharmacists leverage that touch point and improve quality of care.

So, I just want to align and where we're working at is, as you know, with everything going on with PBMs and the workforce of pharmacy is you can't add one more thing to a pharmacist's daily responsibilities, community

pharmacists especially, but we also want to think about payment models that could sustain pharmacists helping to improve care.

So, we have pharmacists in various sectors and I want to think about all of them - like, myself, I don't ever dispense drugs - I work in a clinic and I see patients for disease state management and medication optimization - but we think that the touch point is happening at community pharmacies.

So, how could we sustain ways that pharmacists could help improve outcomes and align with the Quality Strategy?

So, that's what I kind of want to see. We were working with the previous Commissioner to see how we could work through regulations to make a payment model, and we had a meeting with Jessin to discuss some of the legislative - not legislative but regulations.

DR. JOSEPH: Yes, the operational.

DR. FRANCIS: Operational, not legislative. We want to try to stay away from legislative changes that are needed, but how we can make this work, but, then, also, I guess, for

lack of a better term, clinically how we can align our efforts with the top priorities of the state.

So, that's kind of what I would love to hear from you and DMS and bring to us because I think pharmacy is very much looking at population health and value-based outcomes.

MS. PARKER: It has to be part of it.

DR. FRANCIS: Right, right. So, we're really looking to create that model.

MS. PARKER: A holistic approach.

DR. FRANCIS: I would be happy to set an extra meeting if we need to work on this, to create a workgroup. We do have a workgroup through KPhA where we are looking at introducing just legislation, and you'll probably see this if you're following pharmacy legislation, as pharmacist's reimbursement for services within their scope of practice.

So, pharmacies work by collaborative care agreements, but we see patients at my clinic, just as one example, all day long. We don't bill for the visit. We just help to work as part of their health care team to improve medication

outcomes and optimize disease state outcomes.

So, we would love to be able to sustain that and grow that so we can touch more patients, but if you're not able to reimburse a pharmacist, then, how do we make that happen?

So, we want to try to make it something cost neutral as we understand that that's a concern. So, we'd love to look into that some more.

So, if wheels could turn, you could reach out to me. Sharley has my email for sure and I'd be happy to set meetings if that's something you would like to discuss further.

Anything else I'm missing on following up on previous agenda items?

DR. JOSEPH: I would just say we need to make sure the MCOs are involved with that just because whatever we do, it's going to come down to the MCOs just as much as it is for----

DR. FRANCIS: Yes, and I think we kind of talked about that at the last meeting is we said, okay, we're interested in creating a payment model for reimbursement for these services. Let's talk about what we can do from there.

So, I think Aetna has got something in the works here with CPESN, but we need

to look at what outcomes, what measures we're looking at with each MCO.

MS. BATES: And I'm just going to go ahead and address the elephant in the room which is that we're under an active procurement, an open procurement right now.

So, what you're going to probably feel from some of the MCOs is not a willingness to make a bunch of changes right away just because of that. So, just keep that in mind.

There's a lot going on in the budget and this Legislative Session, too, that can impact some of these things that we're discussing.

DR. FRANCIS: But that's also why I wanted to bring it up now. I'd be happy to meet with you to talk to you about, Commissioner, or anyone that wants to talk about the reimbursement for pharmacist's services and why that's such a needed - we're not asking for any additional scope of practice or anything like that. We're just asking to be able to create sustainable models for what we're already doing and expand those.

And we can follow up on that in future meetings, but that definitely is something I would like to see through.

Other things. I know I had emailed Jessin and I just put this on here as a reminder. There were some pharmacists who sent KphA a question about under-reimbursement for compounded prescriptions, and thank you for addressing that.

DR. JOSEPH: Yes, sure. We looked at those claims. These were specifically for fee-for-service, so, this is really nothing with the MCOs on this one.

So, we took a look at the claims. They were paying appropriately to what our logic is set at. And, of course, these are compounded claims that you're talking about, multiple ingredients, but I think the issue with the pharmacist was more for the dispensing fee of compounded claims.

So, we understand that it takes them a while to make these compounds and it takes away from servicing other patients. So, really, the question was, can we increase the dispensing fee.

We can; however, it takes a mountain really. For us, just from our standpoint, what we have to do is send out a cost-of-dispensing survey to the State.

And, then, once we have that

data back, we submit a planned dispensing fee and we can tier it, we can set it up for different pharmacies, and, then, CMS has to approve it. So, that's how we have the $10.64 dispensing fee right now.

It's a CMS-approved dispensing fee. For this one - for that one - sorry - for the $10.64 current one, we didn't have to submit the survey because what we did instead was we utilized our surrounding states to get to a number that CMS was going to approve, but for us to change it, to do it appropriately I think would allow a few months at the minimum.

DR. FRANCIS: Okay. So, is that where you left it with the pharmacist?

DR. JOSEPH: Yes. So, unfortunately, I had to give her the bad news about how much time it would take. I think she understands where we are with that. It's not necessarily a no but it's approximate.

DR. FRANCIS: Okay. She knows that there's someone that she can talk to.

DR. JOSEPH: Yes. So, she can obviously reach out to me.

MS. MILLER: Is it on the back

burner or is it something you see will happen?

DR. JOSEPH: Well, with the legislation going on, I think it's on the back burner until this Session is over.

DR. FRANCIS: Because I can see with all the things of Board of Pharmacy regulations around compounding and the reimbursement, there's pharmacies just saying I'm not doing it anymore and, then, it's really hard for patients to get access, especially children.

DR. JOSEPH: We've made some changes. Some of these products, obviously, are only fourteen days or seven days. So, in the past, our policy was we would only do one dispensing fee every twenty-eight days. We've changed that specifically for compounds to do the seven-day and the fourteen-day supply.

DR. FRANCIS: Thanks for the update.

And I just put one thing on here in regard to the MAC meeting, and, unfortunately, I couldn't attend the last MAC meeting on January 23rd but there was something on the agenda. I was going to ask those that might have been at the MAC meeting.

There was a request from some of the other TACs and MAC members if we could get a consistent pharmacy formulary. Now, we know how idealistic this sounds from our standpoint, but I just wanted to know what happens at the MAC from that. The minutes weren't ready.

COMMISSIONER LEE: As Stephanie stated a few minutes ago, we do have an open procurement with our Managed Care Organizations, but within the sample contract that we have attached to the RFP, we do have an option within that contract to move to one single PDL, but that's an option within the contract and we can explore that after the RFP has been awarded.

DR. FRANCIS: And are we expecting the RFPs to be by July 1st?

MS. BATES: So, the contract that would be active from that award would be January 1st. It would start January 1st.

DR. FRANCIS: And the expected date of announcement would be when?

MS. BATES: We don't know.

DR. FRANCIS: You don't know yet.

MS. BATES: It's a process. So,

the process has to play out.

DR. FRANCIS: Thank you for that update.

So, for the TAC, I don't believe we have any official recommendations to the MAC at this time other than I would probably want to inform the MAC of the potential legislation, even though that will not deal with Medicaid so much. It's more going to deal with commercial, Medicare and everything but Medicaid because Medicaid operationally we're hoping to be able to work something out as pharmacist reimbursement for services.

I already spoke about the PTAC nominations and term expiration. And, so, I think that's everything I had.

The next MAC meeting is not until March 26th. We're used to meeting right before the MAC; but with this year's schedule, it's a little different. So, we should have our minutes and everything ready before the MAC meeting on March 26th but I will plan to attend that.

Is there anything else that anybody has before we adjourn?

MS. HUGHES: Just to alert

everybody to the change in the location of the MAC meeting. It is not in the Capitol Annex. It's over in our Public Health.

DR. FRANCIS: I had that down right.

MS. HUGHES: Yes. I just wanted to draw the attention to everybody in the room.

DR. FRANCIS: And I think April might have some updates for us back on their pilot project.

DR. COX: Yes. I have some CPESN data you were asking about.

So, we did a six-month pre- and post-assessment. So, I mentioned we started on January 1st of 2019. So, we looked at the six-month period prior and, then, the first six months of 2019 to do our first assessment.

So, we looked at a couple of different things. For Emergency Department utilization for the members that are in the program, we were down by 22.2%. Their cost for Emergency Room was down by 49.9%.

For all costs, outpatient utilization, there was a decrease of 19.7% and a decrease in cost of 46.8%.

For inpatient utilization, all costs, we had a 31.7% reduction in claims, but we did have an increase in costs there. So, that part we're kind of researching.

And, then, from a pharmacy utilization, as mentioned, a lot of things that we are identifying are gaps in care. So, we did have a 1.5% increase in pharmacy claims for these members and an increase in cost by 3.9% for pharmacy utilization for the members in the program.

DR. FRANCIS: Which is likely to be expected if they're actually taking their medicines and things like that.

DR. COX: Exactly. So, that means increased adherence, maybe some gap closures, that type of thing.

DR. FRANCIS: Okay. How many patients did you have in that?

DR. COX: So, the number here says sixty members. We engaged with more members than that but these are the ones that actually went from start to finish actually with the care plan process. So, there were sixty members that completed the whole process.

DR. FRANCIS: Sixty members. I

would love to know what dollar amount that is, too.

COMMISSIONER LEE: This sounds like something that's really, really interesting and kind of intrigues me. Is it possible that at the next Pharmacy TAC, we could have some sort of formal presentation with numbers and things that can be given out so that we can see what's going on?

DR. COX: Let me talk to my Director and we will get something together for you guys.

DR. FRANCIS: And this is what I think pharmacists are hoping to move towards and have time to be doing these types of interventions that's happening. Imagine if you multiplied sixty members out to a million, that's going to be quite a cost savings.

MR. CARRICO: That's also what we've been trained to do.

DR. FRANCIS: For sure. Thank you, April, for that quick overview and appreciate everybody's engagement.

Do I have a motion to adjourn?

MR. CARRICO: So moved.

MS. MILLER: And I'll second.

MEETING ADJOURNED